

**KENTUCKY PASRR
PLACEMENT OPTION FORM**

Name _____

SS # _____

Nursing Facility _____

As required by federal regulations, a Pre-admission Screening and Resident Review (PASRR identifies those long-term nursing facility residents with intellectual disability who have been identified as being in need of specialized services (active treatment) for their intellectual disability or related condition. Long-term is defined as thirty (30) months from the date it was first determined that nursing facility services were no longer needed and specialized services for intellectual disability or related condition were needed. These persons have a choice of staying in the facility to have these services provided or moving to an alternate placement, either an Intermediate Care Facility/Intellectual disability (ICF/ID) or a Supports for Community Living Waiver Placement in the community. Specialized services for behavioral health do not take place in a NF; however, a resident who has had a Level II behavioral health evaluation and meets the 30-month criteria shall not be subject to further level of care determinations.

Therefore:

I understand that as a long-term resident of a nursing facility, I have the option of staying and receiving services in the facility, or leaving and receiving specialized services (active treatment) in an alternate placement. These specialized services needs have been identified through the PASRR process and staff from the community behavioral health mental/retardation centers have provided me with an explanation of my placement options. Additionally, as a resident of 30 months or more, there will be no further determinations regarding level of care.

I choose to remain in the nursing facility and receive specialized services there.

I choose to receive specialized services in a Supports for Community Living (SCL) Waiver placement.

I choose to receive specialized services in an ICF/ID.

I chose another community placement and supports.
(specify choice) _____

I am a PASRR client who meets the 30-month requirement. No further determinations regarding level of care are necessary.

Signature of Client/Legal Representative

Witness

Date

Person Completing Form/Date